Appendix F: Nursing Facility Price-Based Payment Billing Guide

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Overview of the Nursing Facility Price-Based Payment Methodology

Effective for claims with dates of service on or after July 1, 2014, DMAS began paying nursing facilities using a new price-based payment methodology. For claims with dates of service between July 1 and October 31, 2014, no billing changes were necessary because each facility's claims were paid the same per diem rates.

Effective for claims with dates of service on or after November 1, 2014, DMAS began requiring facilities to submit Resource Utilization Group (RUG) codes on the claim.

Claim Billing Changes Effective November 1, 2014

- Direct cost component will be adjusted by the RUG weight on each claim to reflect the acuity of the patient.
- Claims will continue to be billed on the UB-04 claim form, the 837-I electronic format, or entered through the Direct Data Entry by the provider as currently billed.
- The RUG code from Z0200 on the qualifying OBRA assessment, plus the two digit 'reason for assessment' code in A0310A, should be submitted on the claim with the 0022 revenue code.

Revenue and Procedure Codes

Under the price-based reimbursement methodology, in addition to billing the revenue codes for room and board and ancillary services, each nursing facility claim must contain at least one revenue code "0022" for each distinct RUGs score assessed during the billing period of the nursing facility claim.

For claims with dates of service between November 1, 2014 and June 30, 2017, the RUG code determined by the RUG-III, 34 grouper, as updated periodically by Medicare, must be reported in the first three digits of the Health Insurance Prospective Payment System (HIPPS) rate code locator on the UB-04 form. For claims with dates of service on or after July 1, 2017, the RUG code determined by the RUG-IV 48 grouper, as updated periodically by Medicare, must be reported in the first three digits of the HIPPS rate code locator on the UB-04 form.

The type of assessment or HIPPS modifier should be reported in the last two digits of the HIPPS rate code. The Medicaid type of assessment is reported in MDS item

A0310A. The total charges for revenue code 0022 should be zero.

Example of values to be reported for an Admission assessment (A0310A = 01) with a RUG in Z0200 of BB2:

Revenue Code	HIPPS Rate Code	Units	Billed Charges	Non-Covered Amount
0022	BB201	30	0.00	0.00

Medicaid Assessments

The Minimum Data Set (MDS) assessment used for Medicaid price-based reimbursement will be Omnibus Budget Reconciliation Act (OBRA) assessments. DMAS will not use Medicare PPS assessments for reimbursement purposes. Only the federally required OBRA assessments listed in item A0310A on the current version of the MDS 3.0 will be used for the price-based payment effective November 1. RUG codes with the HIPPS modifier 99 are not accepted as a valid Medicaid assessment because the assessment is a PPS assessment.

Billing Procedures

Nursing facility providers may continue to bill weekly, monthly, or other intervals. The RUG code billed must match the RUG code documented on the MDS assessment that applies to the dates of service submitted on the claim. Billers may choose to report multiple RUG codes on individual revenue lines on the same claim.

If the MDS is an admission MDS, it will pay from the day of admission until the day before next Assessment Reference Date (ARD) of the appropriately scheduled OBRA assessment.

Adjustments to RUG Billing

If a provider modifies an OBRA assessment, using the modification process as described in the RAI Manual, and the RUG in Z0200 changes, the provider must adjust claims to submit the new RUG code. Providers should follow the claim adjustment procedures to change the RUG code billed for the dates of service affected by the RUG change.

Claim Edits

The following edits will be used in nursing facility price-based payment processing:

Edit	ESC Description
1726	Invalid RUG Group/RUG Group Not Found
1727	Invalid RUG Units
1728	Calculated RUG Amount is Zero
1736	RUG Occurrence Code 50 Not Present

Occurrence Code 50

Like Medicare, DMAS requires nursing facilities to report the assessment reference date with the occurrence code 50 for each RUG code reported in the HIPPS Rate Code field on the UB-04.

The date of service reported with occurrence code 50 must contain the ARD associated with the applicable OBRA assessment. An occurrence code 50 is not required with the HIPPS code reported for default RUG AAA.

Billing Scenarios

Significant Change or Significant Correction

To reflect a significant change in the patient status or significant correction of prior comprehensive or quarterly assessment, nursing facilities should follow the rules for scheduling in the current RAI Manual. These unscheduled assessments restart the schedule for the next OBRA ARD due no later than 92 days from the previous OBRA ARD.

Timing of OBRA assessments is dictated by the rules in Chapter 2 of the current RAI manual. OBRA assessment ARDs may be no later than 92 days apart. There are no state-specific requirements for timing and scheduling outside the RAI manual instructions.

Admission Assessment

If the MDS is an admission MDS, it will pay from the day of admission until the day before the next ARD of the scheduled quarterly assessment.

Assessments for Stays Less Than 14 Days

If a resident is in the nursing facility less than 14 days, the nursing facility may bill the RUG from the completed admission MDS assessment. If the provider elects not to perform the Admission assessment for a stay less than 14 days, the default code AAA00 may be used to set payment for those days.

Medicare Dual-Eligibles

For Medicare crossover claims with dates of service between November 1, 2014 and June 30, 2017, DMAS will map the Medicare RUG-IV, grouper 66 RUG code submitted on the crossover claim to the Medicaid RUG-III, grouper 34 RUG code. For Medicare crossover claims with dates of service on or after July 1, 2017, DMAS will map the Medicare RUG-IV grouper 66 RUG code submitted on the crossover claim to the Medicaid RUG IV grouper 48 RUG code. Both mappings are available on the DMAS website. There are no billing changes for Medicare (Title XVIII) Crossover claims. Part B Therapy Services may continue to be billed as a Title XVIII Part B Crossover claim. These claims shall not be subject to RUG pricing.

If a member exhausts Medicare benefits or Medicare coverage ends and Medicaid becomes the primary payer, the nursing facility should bill the Medicaid RUG calculated and in effect on the dates of service billable to Medicaid.

The Medicaid RUG score can be found in field Z0200A of the most recent MDS with an OBRA reason for assessment in A0310A. The OBRA assessment may be dually coded as a Medicare assessment, but must have an OBRA reason in A0310A. Note that the most recent OBRA assessment may have been before the most recent entry/reentry.

Late Assessments

If the OBRA assessment does not have an ARD within the timelines as defined by the requirements in the Resident Assessment Instrument (RAI) manual published by CMS, the assessment shall be considered late.

The nursing facility shall bill the default RUG code AAA for all of the days from day 93 until the day before the next ARD of a new assessment which has been completed and accepted.

Late Assessment Examples:

Example 1: Late Quarterly

Mrs. Smith had an OBRA admission assessment with an ARD of June 1, 2014. She had an OBRA quarterly assessment on August 27, 2014. Her next OBRA quarterly was due November 27, 2014. Due to the Thanksgiving holiday, her quarterly assessment was missed and had December 1, 2014 as the ARD. The provider must submit a claim that bills the default RUG (AAA00) for November 28, 2014 through November 30, 2014 (3 days). The provider will then bill the December claim using the December 1, 2014 quarterly as usual.

Example 2: Late Annual

Mr. Green had an OBRA annual assessment on November 2, 2013, and quarterly OBRA assessments on February 1, 2014, May 8, 2014, and August 10, 2014. His next OBRA annual assessment has an ARD of November 9, 2014. While this annual assessment is less than 92 days after his last quarterly assessment, it is more than 366 days after his prior annual assessment.

The requirement in Chapter 2 of the RAI manual states the annual is due no later than the ARD of the previous annual + 366 calendar days. The provider will bill the default (AAA00) from November 4, 2014 through November 9, 2014.

Example 3: Missed Assessment

Mrs. Jones had an Admission assessment on November 1, 2014. Her first quarterly was due no later than February 1, 2015. This quarterly was missed, and the facility discovered the missed assessment on February 26, 2015 when claims were being processed. The quarterly ARD was set for February 26, 2015. The provider cannot use this MDS to generate a Medicaid RUG score until it is completed, transmitted, and accepted by the QIES system. Once accepted, the provider must bill February 2, 2015 through February 25, 2015 at the default rate with (AAA00).

Example 4: Late Completion

Mr. Grey had a quarterly MDS on December 12, 2014. His next assessment, an Annual, had an ARD of March 12, 2015 which met the timing requirements for an Annual assessment ARD. Due to staff turnover, this MDS was not completed at Z0500B until April 1, 2015, and not submitted until April 2, 2015. As the ARD

was timely, this assessment does not meet the definition of 'late' for DMAS purposes and there are no assessed default days.

Therapeutic Leave/Leave of Absence (LOA) Billing

Therapeutic leave/leave of absence (LOA) is defined as a temporary absence in which an individual is expected to return to the nursing facility.

For a leave of absence, the resident remains admitted to the Medicaid bed at the facility. The provider will need to make sure that any assessment due during the LOA is completed timely. Setting the ARD early is acceptable.

Note: If there is no assessment generating a RUG score when the next assessment is due, the default days will apply.

- If a resident is approved for therapeutic leave, nursing facilities should continue to bill the therapeutic leave using the appropriate revenue code.
- The RUG units billed must match the covered days on the claim, including the therapeutic leave revenue code units.
- Therapeutic leave revenue units are included accommodation units. If the RUG units do not match the total accommodation units, the claim will deny.

Therapeutic Leave/Leave of Absence (LOA) Example:

Example 1: Therapeutic Leave/Leave of Absence (LOA)

Ms. Black had a quarterly due on November 27, 2014. She left the facility for therapeutic leave on November 26, 2014 and returned on November 30, 2014. The nursing facility will bill the RUG score in effect at the time Ms. Black's quarterly assessment is due. If there is no assessment generating a RUG score when the next assessment is due, the default days will be billed until the ARD of the next OBRA assessment.

Rate Calculation Examples

SFY18 Claim Per Diem Example: Effective July 1, 2017

The direct rate component of each claim will be calculated based on the RUGs score during the claim period.

RUG-IV, Grouper 48 Example	**ES3**	**CC2**	**RAB**	**BB2**	**BA1**
Direct Operating Rate (Case Mix Neutral)	$83.27	$83.27	$83.27	$83.27	$83.27
RUGS IV, Grouper 48 Weight	3.00	1.08	1.10	0.81	0.53
RUG-Adjusted Direct Operating Rate	$249.81	$89.93	$91.60	$67.45	$44.13
Indirect Operating Rate	$65.85	$65.85	$65.85	$65.85	$65.85
Capital Rate	$13.07	$13.07	$13.07	$13.07	$13.07
NATCEPs Rate	$0.00	$0.00	$0.00	$0.00	$0.00
CRC Rate	$0.01	$0.01	$0.01	$0.01	$0.01
Total Facility Per Diem by RUG Category	**$328.74**	**$168.86**	**$170.53**	**$146.38**	**$123.06**

SFY18 RUG-Adjusted Payment Calculation Effective July 1, 2017

For example: RUG code BB2, 30 payment days

(Direct Rate X RUG Weight) + Indirect Rate + Capital Rate + NATCEPs + CRC = Total Per Diem

RUG-IV, Grouper 48 Example	**BB2**
Direct Operating Rate (Case Mix Neutral)	$83.27
RUGS IV, Grouper 48 Weight	0.81
RUG-Adjusted Direct Operating Rate (Rounded to 2 decimals)	$67.45
Indirect Operating Rate	$65.85
Capital Rate	$13.07
NATCEPs Rate	$0.00
CRC Rate	$0.01
Total Facility Per Diem by RUG Category (Rounded to 2 decimals)	$146.38
Number of Units billed	30
Total Allowed Amount	**$4,391.40**

Cost Reporting and Settlement

Although, price-based reimbursement is prospective, charges reported on claims will continue to accumulate on the management reports used for cost reporting. Provider costs will be audited and used for future rate setting.

Reimbursement Methodology and Billing Questions

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